Letters to the editor

We welcome original letters of less than 300 words; we may edit them for clarity and length. Letters may be emailed to journal@doctorsofbc.ca, submitted online at bcmj.org/submit-letter, or sent through the post and must include your mailing address, telephone number, and email address. Please disclose any competing interests.

BC Society of Allergy and Immunology statement on the climate crisis

We, allergists and immunologists of British Columbia, working on the traditional, ancestral, and unceded territory of the Indigenous peoples, want to raise our imperative concerns about the climate crisis, including global warming, glacier melting, rising sea levels, air pollution, water shortages, drought, floods, forest fires, and zoonotic infections, which have caused major damage and disruption.

According to the American Academy of Allergy, Asthma and Immunology, many allergists have reported a wide range of health effects from climate change on their patients, including but not limited to air pollution–related increases in severity of chronic diseases, increased allergic symptoms, and injuries and death due to severe weather. The extreme heat in British Columbia during the last week of June claimed the lives of more than 300 people.

Based on a report from the Asthma and Allergy Foundation of America, warmer temperatures have caused the allergy season in the US to be significantly longer. Warmer temperatures also create more pollens in the air, stronger airborne allergens, and therefore, increased allergy and respiratory symptoms.

As physicians, we know that we cannot have healthy communities without respecting and protecting the environment.

Based on the Paris Agreement in 2015, Canada committed to decreasing greenhouse gas emissions. The report from Environment and Climate Change Canada shows that greenhouse gas emissions in Canada increased between 2015 and 2019 from 723 to 730 megatons of CO_2 equivalent. During the same period, there was a reduction in CO_2 emissions in the UK of more than 10%. This alone shows that Canada has not done enough to address global warming. More than 6 years into the Paris Agreement, Canada has not even submitted the 2020 Nationally Determined Contribution, which was due in February 2020. The delay was blamed on the pandemic. The reality is that the climate crisis is as real as the pandemic and could be even more catastrophic if not addressed immediately.

We are asking the Canadian government to be committed to the Paris Agreement by setting clear pathways and targets for reducing greenhouse gas emissions. We agree with the Canadian Association of Physicians for the Environment, which suggests an independent body of scientific experts who report to Parliament is needed to audit the alignment of the government policy with climate goals.

Canada must quickly progress toward using clean, renewable energy; ban new fossil energy development, including fracking; and instead invest in renewable energy infrastructure. Quebec, New Brunswick, Nova Scotia, and Newfoundland have banned or suspended fracking. This should be expanded to the rest of the country. Pipeline expansions should be canceled.

Fracking and crude oil pipelines harm the environment by contaminating our farmland, using and contaminating excessive amounts of water, causing earthquakes, and advancing global warming by releasing methane gas. Such operations also threaten wildlife and disturb natural ecosystems by industrialization. Such effects have already impaired wildlife and if not stopped will negatively and significantly impact human lives.

We demand the Government of Canada and the Government of British Columbia stop fossil fuel subsidies and instead invest in clean energy.

As settlers on unceded territory, we have a duty to uphold this land to the same standard of care and respect as the Indigenous peoples who originally resided on and who still reside on and protect this land, water, and animals.

—Mandana Kaviani, MD
—Bahar Torabi, MDCM
—Raymond Mak, MD
—Edward Coates, MDCM
—Peter Stepaniuk, MD
—Seung Kim, MD
—Edmond Chan, MD
—Amin Kanani, MDCM
—H.C. George Wong, MD
—Victoria E. Cook, MD
—Kingsley Lee, MD
—Hasan Kular, MD
—Vaishaali Manga Datta, MD
—Stephanie C. Erdle, MD
—Sara Leo, MD
—Siobhan Perkins, BMBS
—Joyce Yu, MDCM
—Shamim Wadiwalla, MBBS
—Manbir Sandhu, MD
—Tiffany Wong, MD

Re: Restrictions on private health insurance

I am disappointed that the *BCMJ* allows Dr Brian Day (who is on the Editorial Board) to use the journal to advance the issues of his own ongoing litigation [2021;63:197]. This is not the first time he has been allowed to do this, and it is a potential conflict of interest.

I am surprised that the *BCMJ* would permit Dr Day to mention that Justice Steeves received care at government expense at the False Creek Surgical Centre: this is totally inappropriate and a serious breach of Justice Steeves' personal

information. It is not at all clear how this disclosure advances what Dr Day is proposing in his editorial. I suggest that the *BCMJ* follow up with Justice Steeves about this disclosure.

—Liz Keay, MD, MHSc, FRCPC, PhD
Victoria

Editorial Board members are free to compose editorials on topics of their choice. The content of each editorial reflects the opinions of the author.

Dr Day has disclosed his potential conflict of interest in his bio on our website.[1] Regarding Justice Steeves' personal information, he himself disclosed at the beginning of the trial that he had surgery (government funded) at Cambie. This was not so, and on being informed of his error, he stated he had erred, and clarified that it was at the False Creek Surgical Centre. This information has been in the public domain since 2016.[2]

The point of Dr Day's statement is to underline the fact that the BC government considers it has the right to send patients who are waiting for surgery to private clinics, but denies citizens that same right. **—Ed**

References

1. Editorial Board. BCMJ. Accessed 4 August 2021. https://bcmj.org/editorial-board.
2. Fayerman P. BC government lawyer says judge disclosed all details of his private clinic surgery. Vancouver Sun. 16 May 2017. Accessed 4 August 2021. https://vancouversun.com/health/local-health/b-c-government-lawyer-says-judge-disclosed-all-details-of-his-private-clinic-surgery.

The fate of historical documents

In May 1954, the editor of the *Vancouver Medical Association Bulletin* wrote, "This issue of the Bulletin is intended to commemorate one of the greatest events in the medical history of British Columbia—the granting of the degree of Doctor of Medicine to the first graduates from the Faculty of Medicine of the University of British Columbia. This is a matter of intense pride and satisfaction to all citizens of British Columbia, and in no lesser degree, we think, it is important to the whole of Canada: for it marks the beginning of a steady stream of well-trained medical men and women, made available to the whole medical structure of our country." This is quoted from a document preserved at the UBC library.

There are many other documents recording the history of our profession, our organization, and our relationships with society. Dr Brad Fritz wrote two histories related to the BC Medical Association and Doctors of BC: a history of publicly funded medicare and a history of the BCMA from 1965. Dr Frank Patterson, an original UBC Medical School teacher, reminisced of many old surgeons in *The Cutting Edge: Reminiscences of Surgery at the Vancouver General Hospital and the University of British Columbia, 1915–1985.* Wendy Cairns recently published a history of UBC Medical School. All these histories rely in large part on original sources.

I recently had the privilege of reviewing the minutes of Medical Staff Association executive and general meetings from Royal Columbian Hospital (RCH) dating back 70 years to 1950. They describe some battles and conflicts, some of which were not solved immediately. Indeed, on the first page of the minutes from 1951, we find the report of the OR service: "Anaesthetists and surgeons have been late in starting operations. The matter is to be brought up at the general meeting and some form of discipline applied to consistent offenders … It was suggested that the offenders be banned from elective surgery booking." One can presume that the punishment was not implemented since the problem has not completely disappeared—or perhaps new generations of surgeons and anaesthetists have started offending again. Who would imagine that we have not learned that lesson!

I happened upon these valuable historical documents because the RCH is currently rebuilding, and the documents were stored in the basement of a building that is now a hole in the ground. Our structures have undergone constant reorganization of one sort or another; consequently, many others will likely face the problem I am currently addressing of what can be done with these important historical documents.

Medical staff associations have become essentially virtual in structure. Storing memorabilia and records is not a priority for health authorities, and carving out a space for them can be a significant challenge. However, without storage for such documents our local history will be lost.

General archives do store medical material—Vancouver General Hospital has many documents in the City of Vancouver Archives, and RCH similarly has some material stored in the New Westminster Archives. However, these organizations suffer from space constraints as well, and I have not found them and other local institutions willing to adopt further material such as the MSA records. There appears to be a NIMBY attitude toward storage of documents—sure, it's important, and good for you for thinking of it, but I'm sorry my backyard is full.

Doctors of BC helps form the collective memory of its physician members. While also challenged for space, it does support an archival system and has staff devoted to that task, and it may be a uniquely suitable repository for such records. It has been said, "Those who cannot remember the past are condemned to repeat it," and indeed many of the issues we contend with today are ones we have seen before. Let us not repeat the errors. I propose that Doctors of BC take on the small job of facilitating this project.

—Richard N. Merchant, MD, FRCPC
Past President, RCH Medical Staff Association

Re: Delay in diagnosis and management of adolescent ACL injuries

I am not surprised by the finding that discrepancies exist in the W0 time between individuals. Further studies on this, as suggested in the article [*BCMJ* 2021;63:211-216], would be helpful. However, I am concerned that the authors' recommendation that all adolescent patients presenting with an acute hemarthrosis be referred for an MRI will only lengthen the W0 time. These patients will join the ever-ballooning pool of people waiting for unnecessary musculoskeletal MRIs.

It also suggests that the presence of a hemarthrosis is, in fact, identified. In today's medical climate of COVID-19, precipitated telephone consultations, and Babylonesque primary care that may not be the case.

The paper referenced in Dr Leveille's article (Ardern CL and colleagues), recommending the need for an MRI, itself references a paper by Kocher MS and colleagues (*Am J Sports Med* 2001;29:292-296) to support this

recommendation. This is perplexing, as the conclusion of that paper is "MRI does not provide enhanced diagnostic utility over clinical examination."

Having recently treated two adolescents with locked knees who presented late due to the wait for unnecessary MRIs, I would advocate for Dr Leveille and colleagues' other recommendation: the urgent referral of all adolescents with an acute knee hemarthrosis (swollen knee) from the primary care or urgent care provider.

—Roger Purnell, MBChB
Orthopaedic surgeon, UHNBC
Prince George

Authors reply

Thank you for your comments on our article [*BCMJ* 2021;63:211-216]. We agree that a primary care provider should see and examine all adolescents with an acute knee injury. In today's health care climate, a screening virtual visit can be offered as an initial evaluation; however, this should be promptly followed by a physical examination if there is any history of concerning symptoms such as swelling, loss of motion, or instability. As is outlined by the College of Physicians and Surgeons of BC practice standard on virtual care, it is unacceptable to defer a physical examination because the virtual care medium does not allow for one. Virtual care is most appropriately used when access to in-person care is provided as needed to follow the virtual consultation. Adolescent patients with an acute knee injury, or history of one, should be promptly examined by a primary or urgent care provider and referred to an orthopaedic specialist when indicated.

An MRI should be requested urgently in all adolescent knee injuries presenting with an acute hemarthrosis but should never postpone referral. Often, a conversation with the radiologist is needed to advocate for a timely MRI in this patient population so that they are appropriately triaged for this investigation. This is our opportunity to advocate for patients who cannot advocate for themselves, and who should be triaged to receive their MRI prior to an adult waiting for an MRI that will not guide clinical management.

It is unfortunate to hear about your recent clinical experience with delayed presentation of adolescent patients with locked knees. Thank you for clarifying the cause of their delayed presentation. We hope that our article will not only bring attention to the problems associated with a delayed presentation in this patient population, but also empower orthopaedic surgeons locally to advocate and provide urgent access clinics for adolescent knee injuries. The solution to this problem is education for our primary care colleagues and accessibility to specialist consultation.

—Lise Leveille, MD, MHSc
—Tessa Ladner, BSc
—Christopher Reilly, MD